THE NEVADA DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES STRATEGIC PLAN 2003-07

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VISION

Our vision is to assist all Nevadan's with mental illness or developmental disabilities to realize their optimal potential as individuals and as valued citizens of their community and state.

MISSION

Working in partnership with consumers, families, advocacy groups, agencies, and diverse communities, the Division of Mental Health and Developmental Services provides responsive services and informed leadership to ensure quality outcomes. This mission includes person-centered services in the least restrictive, most inclusive (normative) environment. This includes prevention, education, habilitation, rehabilitation, and recovery for Nevadan's challenged with mental illness or developmental disabilities. These services attempt to maximize each individual's degree of independence, functioning, satisfaction, and self-sufficiency while ensuring the exercise of individual rights.

STRATEGIC PLAN – QUICK REFERENCE

GOAL 1: Develop and implement evidence-based treatment and interventions for adults and children.

GOAL 2: Ensure that the vision, mission, budget and service systems meet the expectation of the Olmstead decision in that services and programs are provided in the most normative setting.

GOAL 3: Ensure that services are consumer-driven in that services address the interests, rights, and needs of each individual consumer.

GOAL 4: Utilize Technology to improve accessibility to, and availability of, services and the efficient use of resources.

GOAL 5: Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.

GOAL 6: Reduce the rate of suicide and other riskful behaviors in Nevada, which result in injuries, death, etc.

OVERVIEW OF NEVADA

Nevada's is one of the fastest growing states in the nation, with an estimated annual population of 1,998,257 people. According to the U.S. Census Bureau, Nevada ranked 7th in the nation for net migration for the time period between April 2001 and July 2002. Net migration estimates are calculated according to:

- Net Internal Migration – the difference between internal in-migration to an area and internal out-migration from the same area during a time period (within the United States and territories)
- Net International Migration – the difference between immigration to an area and emigration from the same area during a time period (other countries)

Based upon their calculations the estimated net increase for Nevada was 59,357 people and the population also continues to grow due to the difference between the number of births (31, 496) and the number of deaths (15,950).[1] The urban areas of Clark and Washoe County account for the majority of the population (85%) with the remainder of the population (15%) spread across 96,000 square miles and 15 counties.

In addition to the contrast between rural/frontier and urban areas that present barriers to effective service delivery systems, there is an array of social issues that challenge Nevadans, such as (see next page):

1 U.S. Census Bureau (2002). Population Estimates. www.census.gov.

- Approximately 22.1 percent of the adult population (ages 18 and older) in America has a diagnosable mental disorder (e.g., depression, bipolar disorder, schizophrenia, etc.)[2]. The Federal Register estimation methodology indicates that the prevalence rate of SMI among adult is approximately 5.4% (approximately 85,000 Nevadans). In 2002 the Division provided services to approximately 25,000 persons. According to the Division's 2002 Biennial Report, the admitting diagnoses (inpatient and outpatient) were[3]:
  - Mood Disorders (e.g., Major Depression) 41%
  - Schizophrenia and related conditions 30%
  - Other Disorders 12%
  - Substance Related Disorders 10%
  - Adjustment & Personality Disorders 7%
- Certain psychiatric disorders that have an associated increased risk of substance abuse[4]. They include:
  - Antisocial Personality Disorder 15.5%
  - Manic Episode 14.5%
  - Schizophrenia 10.1%
  - Panic Disorder 4.3%
  - Major Depressive Episode 4.1%
  - Obsessive-Compulsive 3.4%
  - Phobias 2.4%
- Recent studies (2001 Continuum of Care applications – north, south and rural) in Nevada have estimated that there are between 13,500 and 21,500 people who are homeless in Nevada (7,000-10,000 in the Clark County, 4,000-5,500 in Washoe County and 2,500-5,000 in the rural/frontier areas).
- Approximately 17% (84,962) of children under the age of 18 have a developmental disorder (e.g., impairments that are physical, cognitive, sensory, etc.)[5].
- In 1999 the crude rate for suicide in Nevada was 22.33 per 100,000 people, which meant that Nevada ranked #1 for incidence of suicide[6]
- According to a recent study conducted by the Nevada State Health Division[6], the top three leading causes of death for consumers of mental health services are:
  - Intentional Self Harm (Suicide)
  - Accidents
  - Diseases of the Heart
- Approximately 2.3% of Nevadans are problem gamblers and approximately 9.9% are at risk of becoming problem gamblers[7].

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2 National Institute of Mental Health (2002). The Number Count. www.nimh.nih.gov.
3 Williams, T. MHDS 2002 Biennial Report (January 2003). Nevada Division of Mental Health and Developmental Services
4 The Mental Health Association of Mississippi. The Bell Ringer (2002). Fall Newsletter.
5 U.S. Department of Health and Human Services – Administration for Children (2002). www.hhs.gov.
6 Wellins B and Yang W. Center for Health Data & Research (March 2002). Mortality Analysis Among Mental Illness Adult Consumers in Nevada from 1998-2000.
7 Volberg, R . Gambling and problem gambling in Nevada (2002). Gemini Research Ltd.

- National composite rankings are determined by the sum of a state's standing on each of the following 10 measures: income and poverty, parental employment, education, language, disability, neighborhood characteristics, age and sex, race, Hispanic origin status, and living arrangements. With #1 being the best, Nevada has a national composite ranking of #35.[8]
- The Nevada economy grew at a rate of 3.7 percent for the period ending November 2000; Las Vegas home builders pulled 23,181 permits for the year, resulting in a 6% gain; Las Vegas home resale's were up 12% through November 2000; apartment vacancy rates stayed between 6-7% throughout 2000.[9]
- Nevada ranks 41st regarding housing wages necessary to afford a two bedroom unit ($15.54 an hour), with wage ranges between $8.72 (West Virginia) and $21.14 (Massachusetts). In 2002 Nevada ranked 7th for least affordable housing in "combined non-metropolitan areas". Additionally, Nevada had one of the largest changes in housing wage (amount needed to afford rent) for combined non-metropolitan areas between 2001-2002 (3.90%, ranked 3rd).[10]
- Nevada ranked 36th in mental health actual dollar and per capita expenditures by state for fiscal year 2001[11]

INTRODUCTION

The Division of Mental Health and Developmental Services (MHDS) is one of eight Divisions within the Department of Human Resources (DHR). Chapters 433 and 435 of the Nevada Revised Statutes are the laws that govern mental health and developmental services. Both the Commission on Mental Health and Developmental Services and the Mental Health Planning Advisory Council provide are part of the Leadership team that assists in developing the strategic plan that outlines the way in which services are provided in Nevada.

The FY02-03 budget (state general funds, federal funds, and fees/charges) for the Division of MHDS totaled $131,802,440 (MH - $71,074,706 and DS - $60,727,734). According to information compiled by The National Research Institute (NRI), the total expenditures in Nevada for FY01 was $112,859,120, which meant that Nevada ranked 36th among the fifty United States.[12] According to the Biennial Report, the Division provided services to over 25,000 Nevadans in FY02 (22,341 – MH and 3,513 – DS), an increase of 9% from FY01.[13]

8 Annie E. Casey Foundation. Kids Count Census Data (2002). www.aecf.org/kidscount.
9 U.S. Housing Market Conditions (2001). U.S. Department of Housing and Urban Development. www.huduser.org.
10 National Low Income Housing Coalition. Farther Out of Reach Than Ever (2002). www.nlihc.org.
11 Survey and Analysis Branch, Funding Sources and Expenditures of State Mental Health Agencies for FY2001. (2002). National Association of State Mental Health Agency Program Directors Research Institute, Inc.
12 National Research Institute. Draft Tables: Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 2001 (October 2002)
13 Williams, T. MHDS 2002 Biennial Report (January 2003). Nevada Division of Mental Health and Developmental Services

Mental health and developmental services agencies are located throughout Nevada as follows:

- SOUTH (Clark County) – Southern Nevada Adult Mental Health Services and Desert Regional Center
- NORTH (Washoe County) – Northern Nevada Adult Mental Health Services and Sierra Regional Center
- RURAL (Balance of State – including Mesquite in Clark County) – Rural Clinics Administration and Rural Regional Center
- Statewide Forensic Services – Lake's Crossing Center in Sparks

The Division relies on a variety of national informational sources in developing and revising goals, objectives, and strategies that are included as part of its Strategic Plan. These can include, but are not limited to, the following publications/reports:

- Suicide Prevention Now: Linking Research to Practice by the Center for Disease Control within the Department of Health and Human Services
- The Department of Health and Human Resources Strategic Plan
- Healthy People 2010: A Systematic Approach to Health Improvement
- Strategic Plans from other states: California, Florida, Oregon, Massachusetts, Missouri, New York, and Rhode Island

As a state public agency, the Division works closely with a variety of different stakeholders (e.g., direct consumers, family members, community-at-large, etc.). Consensus occurs because there is a commitment by all stakeholders to a public mental health and developmental services system that meets the needs of Nevada's citizens. The Nevada Alliance for the Mentally Ill (NAMI) is active in each region and has representation at most local advisory board meetings and the meetings of the Commission of mental Health and Developmental Services. The Mental Health Planning Advisory Council (MHPAC) works with the Division and provides input on the Division's Mental Health Plan.

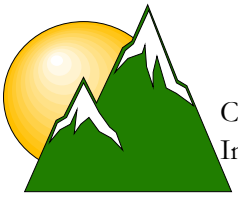
STAKEHOLDER VALUES

The Division of Mental Health and Developmental Services (MHDS) strategic planning process began in 1995 with a values clarification study[14]. Because an effective strategic planning process involves stakeholder involvement and feedback, consumers, family members, advocates, service providers, legislators, state administrators, the general public, and law enforcement personnel were surveyed to identify value statements on which to base future program and policy development. The survey instrument used by the Division was based upon national research and stakeholder feedback. This survey resulted in the development of the following values (see following pages):

14 Hardy, P. Values Clarification Study (1995). Nevada Division of Mental Health and Developmental Services

VALUES FOR MENTAL HEALTH

Consumers contribute to the community through positive behavior, including involvement in community organizations and activities. Consumers remain in the community as long as possible, and are treated in the hospital only when absolutely necessary.



Consumers are educated about their disorders and the treatments/services available, including self-help groups. Consumers are actively involved in establishing goals for treatment, and in making decisions about treatments and services needed.

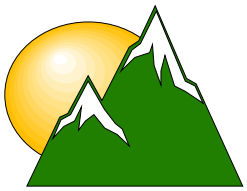
Consumers feel good about the kinds of services received and the results. They believe that services are delivered in a respectful and caring manner.

Consumer's families are informed about and involved in their relative's care, when appropriate. Families are supported in coping with the practical and emotional difficulties of having a relative with mental illness. Families' burden due to their relatives' illness is minimized.

VALUES FOR MENTAL HEALTH

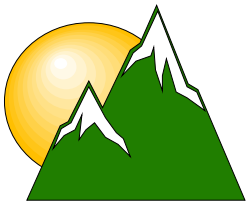
Consumers make progress toward their potential in working or going to school, and in skillfully relating to others.

Consumers recognize themselves and are recognized by others as persons who are equal with others, who have worth and dignity, and who have needs, hopes, dreams, and preferences, just as others do.



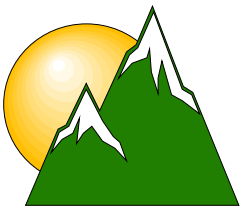
Consumers and others in the community are protected from dangers of the consumer's own behavior. In addition, others are prevented from harming or taking advantage of consumers.

Consumers gain skills needed to handle the problems that come with having a mental illness, including skills needed for coping with emotional reactions to having a mental disorder, for dealing with stress, for having insight, and for meeting basic needs.



Consumers' symptoms are reduced, stabilized, or prevented through treatment. Such symptoms may include problems with thinking, behavior, and moods.

VALUES FOR DEVELOPMENTAL SERVICES



Choices

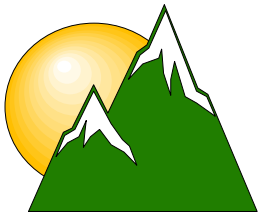
People choose personal goals and services. Choices include where to live and work and how to use free time.

People are included in the community

People live and participate in the community interacting with others and fulfilling different social roles.

Relationships

People have friends and relationships and remain connected to their natural support network.



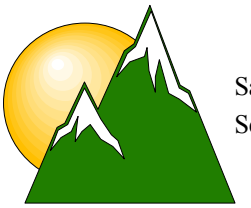
Rights

People exercise their full rights as citizens and if their rights are limited, they are afforded due process.

VALUES FOR DEVELOPMENTAL SERVICES

Health

People have health care services adequate to achieve the best possible health.



Safety and Security

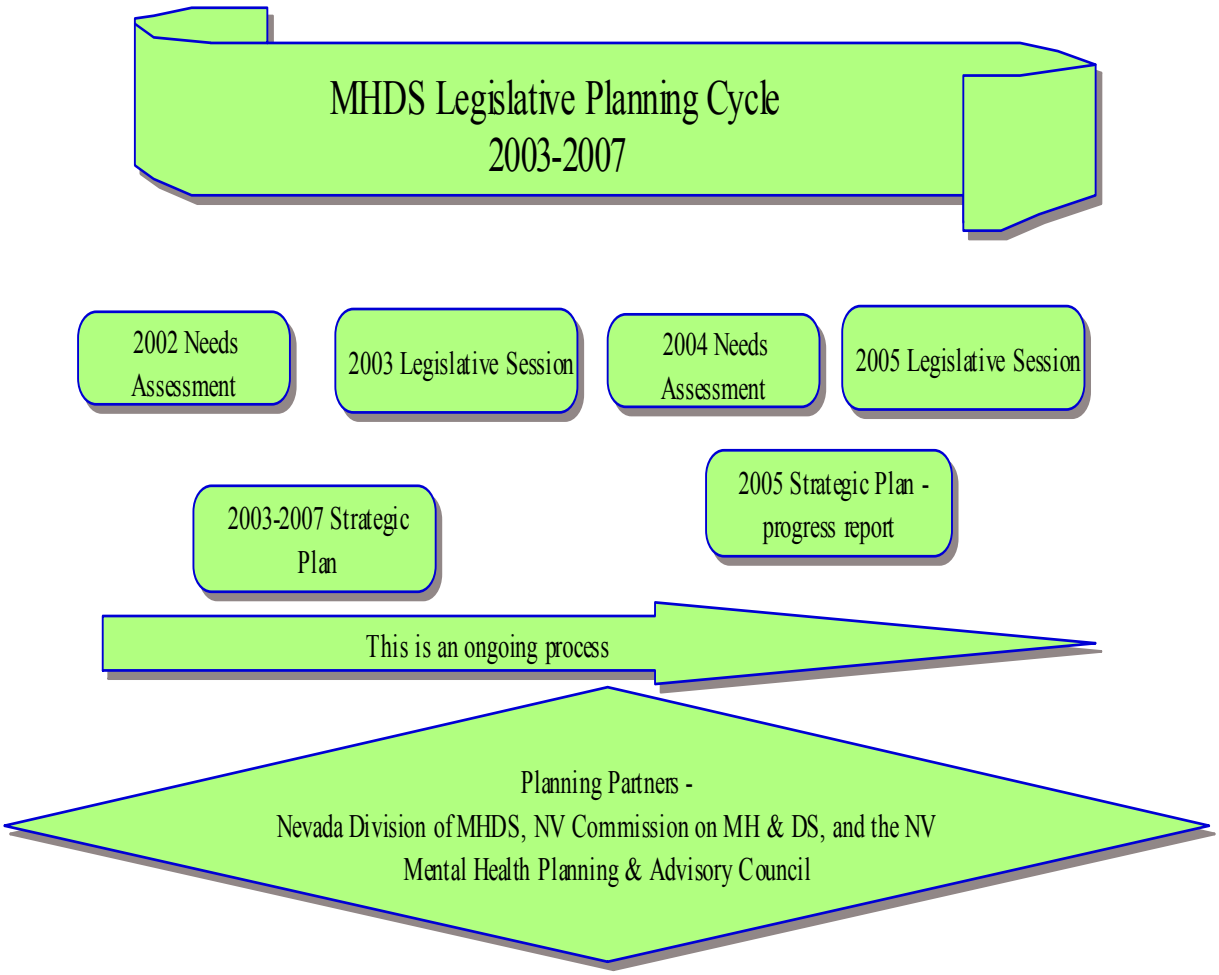
People are safe, free from abuse and have economic security in their life.

Satisfaction

People are satisfied with the services and assistance they receive in pursuing their goals.

MHDS STRATEGIC PLANNING PROCESS

In 2000, the Division updated the 1997 Strategic Plan to align with national standards, service gaps, budget and program planning. Additionally, the Division developed a reporting timeframe consistent with the legislative planning process, which includes the MHDS Needs Assessment (every even-numbered year) and strategic planning reports (odd-numbered years). This planning process is depicted in the graphic on the next page:



The 2002 Needs Assessment[15] also indicated gaps in more than just service by noting needs of staff, such as:

- Training
- Emergency Management
- Information Management

Based upon this report, specific FY04/05 budgets were developed and presented to the 2003 Nevada Legislature. This 2003 Strategic Plan and the upcoming 2004 Needs Assessment are developed to assist MHDS through the FY06/07 biennium. The figure on the next page illustrates how the Strategic Plan fits into the Division's planning process:

15 Valentine L. 2002 Mental Health Needs Assessment. (January 2002) NV Division of Mental Health and Developmental Services, Carson City, NV

MHDS STRATEGIC PLAN FROM 2003-2007

A Strategic Plan is not a compilation of all actions necessary to achieve a goal or an objective. Implementation strategies for each objective are not inclusive of everything necessary. Rather, they illustrate the general direction the Division plans to take over the next four years. Every spring the Division of MHDS will submit a Strategic Plan Progress Report that will discuss progress on the Strategic Plan, actions taken to date, any changes that are to be made based on what has previously been done, etc.

This 2004 Strategic Plan uses a simplified plan format that identifies goals, program objectives, and measurable strategies. The MHDS strategic plan format is shown on the next page:

❶ GOAL: **Framework for detailed planning that reflects the general administrative direction of the plan.**

❷ OBJECTIVE: **Specific and measurable targets for accomplishing a goal**.

❸ STRATEGY: **Activities linked to specific objectives**.

The 2003-2007 Strategic Plan includes six overall goals and multiple objectives for each goal. Each objective is refined to include specific strategies that will be undertaken by MHDS.

The goals and associated objectives and strategies for the Division of MHDS are shown below:

GOAL 1: Develop and implement evidence-based treatment and interventions for adults and children.

According to the Substance Abuse Mental Health Services Administration (SAMHSA) Evidence-based practices are "the conscientious, explicit, and judicious use of current best evidence in making decision about the care of individuals." Currently SAMHSA has developed toolkits for the following six evidence-based practices:

- *Medication Management*
- *Assertive Community Treatment*
- *Supported Employment*
- *Family Psychoeducation*
- *Illness Management and Recovery*

- *Co-occurring Disorders; Integrated Dual Disorders Treatment*

The Division of MHDS currently intends to focus on the first three.

1.1. Objective: Budget requests for each biennium will emphasize programs that are proven to have met national "best practices" standards (evidence-based).

1.1.1. Strategy: Apply for and secure federal grant funding (e.g., Substance Abuse and Mental Health Services Administration) to pay for implementation and continuing education regarding Evidence-Based Practices (EBPs).

1.1.2. Strategy: Link budget planning and legislative requests to a sequence of planning activities (e.g., Needs, Assessment, Strategic Plan, etc.) to ensure that efficacious programs are sustainable at the state level.

1.2. Objective: Develop a training plan each biennium that will ensure that all staff are trained to criterion in the evidence-based program to be implemented.

1.2.1. Strategy: Work with national organizations and other states (e.g., EBP Best Practice sites, JCAHO, etc.) for training, consultation and support.

1.2.2. Strategy: Coordinate quality assurance/performance improvement and training efforts to achieve maximum adherence to standards and EBPs.

1.2.3. Strategy: Develop necessary infrastructure to convene professional training programs (e.g., Service Coordination Conference) that focus on dissemination and implementation of evidence-based practices.

1.2.4. Strategy: Develop materials regarding EBP for use and billing consensus, training, and ongoing support for a range of stakeholders, consumers, family members, and state and local advocates/agencies.

1.3. Objective: All agencies shall be working toward accreditation (2007).

1.3.1. Strategy: Quality Assurance/Performance Improvement reviews will focus on adherence to accreditation standards (e.g., The Council, CARF, JCAHO, etc.), outcome measures and program measures of fidelity (EBP)

1.3.2. Strategy: Develop and strengthen quality assurance/performance improvement programs that are linked to evidence-based practices (including licensure, credentialing, accreditation, treatment guidelines and algorithms).

1.3.3. Strategy: Ensure that residential support programs are reviewed to ensure compliance to "best practices" standards and use review findings in planning resource allocation.

1.3.4. Strategy: Division and its agencies will partner with national organizations and other Divisions/Agencies regarding licensure/accreditation

1.3.5. Strategy: Dedicate staff and infrastructure necessary to move from initial pilot efforts to system and state-wide implementation of evidence-based practices.

1.3.6. Strategy: Utilize databases to analyze and develop innovative service systems (treatment and interventions) that have decisions that are data driven.

GOAL 2: **Ensure that the vision, mission, budgets and service systems meet the expectation of the Olmstead decision in that services and programs are provided in the most normative setting.**

2.1. Objective: Develop a coordinated array of community-based (most normative) treatment services that are tailored to each individual being served (age, sex, race and culture) and facilitate entry into treatment

2.1.1. Strategy: 75% of the Division's budget will be utilized for community-based services so that more restrictive services are available for people most in need of protective services (safety and symptom reduction).

2.1.2. Strategy: Build a budget base that is based on an accurate (valid and reliable) methodology that is used to determine caseload projections (CLEO).

2.1.3 Strategy: Maintain accurate waiting lists.

2.1.4. Strategy: Analyze institutional care to ensure that there is continuity of treatment (NOTE: Nevada continues to decrease institutional beds compared to the national average).

2.1.5. Strategy: Overcome stigma (e.g., mental health, developmental disabilities, substance abuse, etc.) and expand public awareness of effective treatments.

2.2. Objective: Develop an evidence-based medication management system.

2.2.1. Strategy: Continue to make available newer, safer medications.

2.2.2. Strategy: Expand the current Nevada Medication Algorithm Decision Matrix (used in medication management of schizophrenia) to include SSRI medication management in the treatment of mood disorders.

2.3. Objective: Develop provider capacity to support people with unique or atypical support needs.

2.3.1. Strategy: Continue to advocate and support provider rate increases that will ensure continuity and quality of care.

2.3.2. Strategy: Increase the number and types of community-based residential placements.

2.3.3. Strategy: Improve the flow of information to consumers, families, advocates, general public and providers regarding community residential options.

2.4. Objective: Continue to expand HOME and Community-Based Waiver and psychosocial rehabilitation services.

2.4.1. Strategy: Add services not already in Waiver – respite and family support.

GOAL 3: **Ensure that services are consumer-driven in that services address the interests, rights, and needs of each individual consumer (individual served).**

Every agency within the Division of MHDS offers personalized assistance that builds upon individual strengths and abilities. Every consumer is empowered to exercise choice and take charge of his or her life.

3.1. Objective: Expand the foundation of a recovery-oriented system of care in Nevada that includes, but is not limited to, consumerism in health care, disability rights and evidence-based psychiatric rehabilitative practices (this last one specific to mental health).

3.1.1. Strategy: Increase the number of consumers that participate in program planning (Consumer Assistance Program – CAP) and ensure that CAP objectives are implemented.

3.1.2. Strategy: Encourage and support the training of family members in treatment and advocacy issues (e.g., Family to Family training offered by NAMI).

3.1.3. Strategy: Assess and identify risk factors that are barriers for consumers and implement a transition plan to ensure people move toward normative settings and achieve their goals.

3.1.4. Strategy: Ensure that services are person-centered and sensitive to age, race/ethnicity, background, etc. (culturally competent).

3.2. Objective: Augment state funds with federal funds to ensure continuity of care (from homelessness to support and/or independent living with the community of choice) for persons at risk (e.g., homeless, co-occurring disorder, other riskful behavior, etc.).

3.2.1. Strategy: Expand safe/affordable housing options state wide by renewing existing grants and applying for additional federal dollars.

3.2.2. Strategy: Use the CMHS Block Grant to initiate evidence-based practices.

3.2.3. Strategy: Advocate at the national level for an increase in PATH funding for Nevada and use increased funding to increase outreach, engagement, service provision, etc. for those persons who are currently disenfranchised from the service system and in need of assistance.

3.2.4. Strategy: Apply for additional EBP grant funds.

GOAL 4: Utilize technology to improve accessibility to, and availability of, services and the efficient use of resources.

4.1. Objective: Implement new creative SocioMedics Software/Window NT architecture as part of a comprehensive statewide MIS for all public mental health programs.

4.1.1. Strategy 1: Implement patient management and pharmacy modules across all MH agencies in FY04.

4.1.2. Strategy 2: Implement electronic medical records (clinician workstations) at NNAMHS and Carson City Rural Clinics in FY05.

4.1.3. Strategy 3: Complete implementation of MH MIS including electronic clinical workstations at all MH agencies by end of FY06.

4.1.4. Strategy 4: Upgrade and develop a standard communications infrastructure for MH and DS programs, which will provide primary communications to state resources (MIS, Internet) as well as divisional business administration (email, scheduling, file transfer, etc.).

4.2. Objective: Implement new Creative SocioMedics Software/Windows NT architecture as part of a comprehensive statewide MIS for all public developmental services programs.

4.2.1. Strategy 1: Reorganize and acquire additional IT support to meet the division's need to support agency and statewide application development, reporting and data analysis.

4.2.2 Strategy 2: Provide training to key staff to support improved MHDS data infrastructure (including hardware, software, and audio-visual equipment).

4.3. Objective: Enhance/develop the division-wide information technology support network.

4.3.1. Strategy 1: Conduct a functional requirements analysis (gap analysis) for all developmental service programs during FY06.

4.3.2 Strategy 2: Based upon DS gap analysis completed during FY06, develop implementation budget for DS MIS for consideration during FY06-07 Legislature.

4.3.3 Strategy 3: Implementation of Creative SocioMedics MIS across all DS agencies during FY06.

4.4. Objective: Facilitate the utilization of telemedicine to improve Division services and increase education opportunities in the rural areas.

4.4.1 Strategy: Rural Clinics Administration will explore and plan for the utilization of telemedicine in the rural/frontier areas of Nevada.

4.4.2 Strategy: Based upon the above plan, Rural Clinics Administration will develop a budget request for the FY06 legislature.

4.5. Objective: Increase videoconference capacity throughout the state to utilize this type of resources rather than expensive alternatives (e.g., travel).

4.5.1 Strategy: The Division and its agencies will work with the Health Department to provide videoconference capacity between the Division Central Office and the Division agencies.

4.5.2 Strategy: Lake's Crossing Center (LCC) Administration will provide the capacity to have videoconferencing ability between the LCC facility and the Clark County Jail.

GOAL 5: Update and maintain a plan to respond to emergencies and disasters in Nevada in a timely and effective manner.

5.1. Objective: Update and enhance the existing MHDS response plan and address bioterrorism.

5.1.1. Strategy: Increase the number of people trained to provide critical incident stress management.

5.1.2. Strategy: Increase the number of crisis counseling responders.

5.2. Objective: Seek federal funding for the Division to develop interagency and interstate agreements to enhance emergency response and coordination.

5.2.1. Strategy: Collaborate with other agencies to submit funding requests to result in a wider array of trained responders.

5.2.2. Strategy: Once funding is in place, develop MOUs with other state mental health authorities to maximize response capacity.

GOAL 6: **Reduce the rate of suicide and other riskful behaviors in Nevada, which can cause injuries, death, etc.**

6.1 Objective: Assist the Legislature in drafting legislation to establish a Statewide Suicide Prevention Plan within the Department of Human Resources (DHR).

6.1.1. Strategy: Provide testimony at Legislature.

6.1.2. Strategy: Assist DHR and all other Division agencies in developing and implementing the Suicide Prevention Plan.

6.1.3. Strategy: Implement and maintain an accurate Resource Directory for people seeking programs for suicide prevention.

6.1.4. MHDS Administrator to continue to participate as a national advisory board member with the National Suicide Prevention Center in Las Vegas, NV.

6.2 Objective: Collect data annually (serious incidents, denial of rights, seclusion/restraint) and use reports to identify and problems in order to develop corrective action and identify ongoing training issues.

6.2.1. Strategy: Use various management information systems currently in place within agencies and the Division Central Office to track and trend the above data in order to identify systems issues and develop plans (e.g., training, budget requests, etc.) aimed at ensuring a safe environment for consumers, visitors, and staff.

6.2.2. Strategy: Collaboration with other agencies to report on incidents of riskful behavior (including suicide attempts), injuries, death, and suicide.

6.2.3. Continue to export MHDS caseload data in order for the Health Division to generate mortality studies and other topical studies.

PROGRESS AT A GLANCE (1997-2000)

How effective has MHDS been at accomplishing its goals? To gain a longer-term comparison of MHDS strategic goals and a thumbnail of how Nevada stacks up to key available national comparisons, this report also includes a "Progress-At-A-Glance" section.

In addition, this 2003 report now includes formal involvement of two MHDS governance, and advisory, bodies:

✓ Nevada Commission on Mental Health and Developmental Services, and
✓ Mental Health Planning & Advisory Council (MHPAC)

The participation of these two key federal and state governance structures assures involvement of professionals, family members, and consumers in the development of the 2003 MHDS Strategic Plan and budget development. The 2003 Strategic Plan was formally reviewed by these strategic planning partners in scheduled open meetings. MHDS strategic planning partners are listed on page 2 of this document. This enhanced MHDS planning process strives to use consumer networks as part of the legislative planning process.

Since beginning the Strategic Plan process in 1997 the Division of MHDS has met many of the objectives it has set out to accomplish. It has specifically met all of the objectives identified in the 1997 Strategic Plan. The objectives that were met in the 2000 plan include:

- 2000 Strategic Plan – Objectives that have been met:
  - ☺ FY02-03 budget requests will only be for programs that are proven to be cost effective and meet national quality standards.
  - ☺ Agency budgets will commit at least 65% of funding to community-based programs.
  - ☺ By 12/31/00 develop a service plan that allows institutional placements for only those consumers whose current needs cannot be met through community-based services.
  - ☺ Each agency will ensure that the Division's WEB page contains information regarding available services and how to access services by 9/30/00.
  - ☺ Keep the Division WEB page current.

Objectives from the 1997 and 2000 Strategic Plan that were met after the indicated completion date include:

- Develop a training plan that will ensure all staff are knowledgeable of national quality standards by 12/31/00. **STATUS:** This objective was accomplished but not by the deadline of 12/31/00.
- By 7/1/01 identify methods of providing incentives to providers to not only provide services but to provide quality services. **STATUS:** Work regarding AB513 has been accomplished but was not done by the deadline date of 7/1/01. This objective will be restated in the 2002 Strategic Plan.
- Conduct reviews of MHDS business processes to identify areas for improvement.

- Improve safety by 12/31/00. **STATUS:** These reviews are in the process of being conducted but not all agencies have been reviewed therefore the deadline date of 12/31/00 was not met.
- Improve safety by 12/31/00. **STATUS:** Work regarding this objective (e.g., workplace violence, worker's compensation, etc.) is an ongoing issue. Work was started and will continue at the agency level.
- By 6/30/02 all persons served will have a person-centered plan. Person centered planning is matching supports and resources to what the person wants and needs for their future. **STATUS:** The DS side met this but will continue to meet this objective. The MH side is continuing to work on this objective.
- Consumers will participate in program planning decisions by 7/1/00. **STATUS:** This objective was accomplished but not by the deadline of 7/1/00, however, it will continue to be an objective in the 2002 Strategic Plan.
- Every Division office should have email by 6/30/01. **STATUS:** This objective was accomplished but not by the deadline of 6/30/01.
- Create the ability of the Division to utilize telemedicine to improve services and increase educational opportunities by 12/31/00. **STATUS:** This objective was not met and will be restated in the 2002 Strategic Plan, focusing on many important technology-based issues.

Objectives that were partially met or not met the Division of MHDS are refined (changed or modified) in this 2003-2007 Strategic Plan. NOTE: This plan will be reviewed by Division of MHDS Leadership in 2005 and a progress report will be issued at that time.